



CLINICAL MEDICINE

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Editorial

Adolphe Burggraeve

Father of Dosimetric Therapy

REFORMS for the good of the people rarely originate from established authority, which always tends to maintain conservative inertia. The successful leader of a reformation must know, personally, the ills that affect the people and the weakness of the efforts put forth by those whose reputations are established, and must have a genuine love for mankind. Of such was the great Belgian surgeon and therapeutic innovator, Adolphe Burggraeve, who has often been likened to Hippocrates, in that both were philosophers, keen and close observers, and consummate clinicians, who lived to a great age, always striving to improve the status of Medicine as they had found it.

Burggraeve was born October 3, 1806, in Ghent, Belgium, where he grew to manhood and became a Doctor of Medicine, a surgeon, professor of anatomy, and then of clinical surgery at the University of Ghent, where he served until he attained the honor of Professor Emeritus (when he was about 60 years old) and was made a Member of the Royal Academy of Brussels, meanwhile retaining his position as chief surgeon of the Civil Hospital of Ghent. Forty years of his life were spent as a surgeon, and most of the remainder in es-

tablishing the principles of Dosimetric Therapy.

As a surgeon, Burggraeve introduced the use of cotton batting as a padding between splints and the body, in treating fractures, and as a *compression dressing* for tumors and other conditions requiring pressure in their treatment. This method is now coming into wider and more general use, and is looked upon, by many, as being a new idea.

About 1854, he became profoundly and acutely dissatisfied with the therapeutic nihilism that was then prevalent. His optimistic nature and his honest conscience could not accept the idea that the evils of disease were irremediable, and he began searching for something to do about it.

About this time, a Dr. Mandt, who had been physician to Czar Nicholas I, of Russia, and who, years before the discovery of bacteria, had a fairly clear idea of "germs" and disease, announced a new method for treating Asiatic cholera, which had met with considerable success, but which (as usual) was ignored by the "authorities." Burggraeve, however, studied this work, became impressed with its possibilities, and applied his active mind to developing and perfecting it.

By 1870, he had elaborated a new conception of a specific attack upon disease processes, but the "authorities" of Belgium rejected it; so, at the close of the Franco-German war, in 1871, he went to Paris, where he made the acquaintance of the scholarly and scientific retired pharmacist, Charles Chanteaud, who immediately recognized the value and scope of Burggraave's ideas and undertook to assist him in correlating and popularizing them. From this association sprang the doctrine of dosimetric therapy: "To administer minute, nontoxic doses of pharmacologically specific active principles, at brief intervals, until therapeutic or toxic results appear, and then give them less frequently, as indicated, until a cure is attained."

"Dosimetry" was enthusiastically welcomed in France, except by the "authorities," and Burggraave went, as an evangelist of this new therapeutic gospel, to Spain, Portugal, Italy, Switzerland, England, Holland, and Denmark, where he gathered many disciples. In 1878 he presided over a brilliant Congress of Dosimetrists, in Paris, and in 1881 (when he was 75 years old), over another in Madrid, Spain, which was a veritable triumph. His ideas were introduced in the United States by Drs. W. T. Thackery and W. C. Abbott, and were first widely publicized in *The Alkaloidal Clinic*.

In 1872 he founded the *Repertoire Universel de Médecine Dosimétrique*, of which periodical he was the sole editor until 1894, when he had reached the age of 88 years. After that he continued studying, writing, and practicing his profession almost up to the time when he passed to his rest and reward in 1902, at the patriarchal age of 96 years.

All his life, Burggraave was a profound catholic, and eager student, an inspiring teacher, and a prolific writer. More than 30 considerable books from his pen were published, including historical monographs on Jenner, Vesalius, and Koch, and at least one volume on medical economics, among the many dealing with the therapeutic philosophy which he founded.

In person, he was a tall, massive man, with a magnificent physique and an almost unbelievable fund of energy and

enthusiasm, which enabled him to carry out tremendous undertakings, at which men with a lesser endowment would have failed.

This truly great pioneer in therapeutics deserves to be better known to American physicians than he now is,* especially since the general principles (if not the detailed technics) of the philosophy he promulgated are constantly coming into wider recognition and use.

♦

Wisdom comes through what a man sees when he looks.—MANLY P. HALL.

♦

Cerebrospinal Fever

EPIDEMIC cerebrospinal fever is a disease of wartime, of over-crowding and poor sanitation, and of the winter season, so our readers, civilian and military, will be wise to study up on it now.

In civil life it is not highly infectious and epidemics are usually localized and irregular in distribution; but among troops in barracks, particularly recruits and young soldiers and especially in the tropics, killing pandemics may occur.

The infection is spread directly from man to man, by droplets, and apparently healthy carriers are important disseminators. The carrier rate increases inversely with the distance between bunks, cubic space being a lesser factor. Overexertion, depressing mental and physical surroundings, and crowding are predisposing circumstances.

The causative organism is a meningococcus, of which there are several strains, and is present in the nasopharynx, in patients, healthy contacts, and carriers, as well as in the cerebrospinal fluid and sometimes in the blood (meningococcus septicemia), so that it can be detected by careful examination (with cultures, as in diphtheria), which should be made in every suspicious case and, in the presence of an epidemic, as a routine in entire commands or groups. All patients and carriers should be strictly isolated until proved free of infection.

Since an emergency prepared for

*Those who wish to make a further study of Burggraave are referred to the excellent article by Dr. E. M. Epstein, in *The American Journal of Clinical Medicine* for January, 1909, page 24, from which most of the material in this sketch was obtained.—Ed.

is no longer an emergency, it behooves all physicians, especially medical officers of the armed forces, to equip themselves with the necessary information at once, and be ready to act upon it at a moment's notice.

Any man may make a mistake, but none save a fool will continue it.—CICERO

Whooping Cough

CONTRARY to the popular impression among laymen (and even some physicians), pertussis, or whooping cough, is one of the most serious, and even fatal, diseases of infants and young children, and should be given serious consideration and attention by every clinician who sees such cases.

It is now possible to immunize babies prenatally, by giving the mothers large doses of pertussis vaccine, subcutaneously,¹ and this method, while not fully established, is worthy of trial whenever it is practicable.

Mitchell² reported that pertussis vaccine (Sauer's type) protected 95.4 percent of a group of 31 children from whooping cough, over a period of five years, and feels that it should be given routinely to all babies over the age of 6 months.

Care should be taken to keep up the general resistance of all young children, by seeing that they get adequate quantities of vitamins and by other meas-

ures, and to protect them against exposure to this disease as much as possible.

If pertussis develops, good results, in reducing the number and severity of the paroxysms and shortening the period of illness, have been reported following the use of *Elizir Bromaurate*.³ Belladonna, in rather large doses, also seems to be helpful.⁴

Pertussis Soluble Antigen (Sharp & Dohme), for topical application in the nose, especially if used early and faithfully, has shown some good results as a

specific treatment; and Burkard,⁵ reported remarkable relief of paroxysms following hypodermic injections of *adernal cortex extract*, from 3 to 7 minims every other day for four doses. All of these methods, especially the prophylactic ones, are worthy of trial, as circumstances permit.

Perhaps the chief points to be impressed on the general clinician are (1) that whooping cough is a dangerous disease;

(2) that he must convince his patients of that fact, so that they will cooperate with his efforts; and (3) that there is now something to be done about it.

NEXT MONTH

Dr. Arnold S. Jackson, of Madison, Wis., will present a brief and helpful outline of diseases of the thyroid gland, with illustrations.

The Graduate Course will offer a symposium on "Jaundice," by a pathologist, an internist, a surgeon, and a roentgenologist.

COMING SOON

"Ascorbic Acid in Essential Hypertension," by Nathan S. Davis, III, M.D., F.A.C.P., Chicago, Ill.

"Cremation," by George B. Lake, M.D., Waukegan, Ill.

¹ See Cohen and Scadron, in *CLIN. MED.*, Oct., 1942, p. 301.

² Mitchell, F. T., in *Southern M. J.*, Apr., 1940.

³ Gold Pharmacal Co., New York City.

⁴ See *CLIN. MED.*, Oct., 1942, p. 314.

⁵ Burkard, A. F., in *Med. World*, Oct., 1937.

LOVE AND WORDS

*If I but loved you less, my tongue and pen
Could weave wild, tender rhapsodies above you;
But since I love you as I do, why then
I have no words to say but just, "I love you."*

G. B. L.

in *Quickening Seed*.

LEADING ARTICLES



Coccidioidomycosis*

By CHARLES D. MARPLE, M.D., San Rafael, Calif.

Although coccidioidomycosis is not very widely distributed in the United States, it is a differential diagnosis that should be kept in mind, and Dr. Marple shows how to recognize it.

FUNGUS: *Coccidioides immitis* (Rexford and Gilchrist).¹

Distribution: Recognized endemic regions are the San Joaquin Valley of California; scattered regions in Southern California, in Texas, and in Arizona; and the Chaco region of the Argentine.

Sporadic cases have been reported from many counties in California, from many states in the United States, and a few cases from abroad.

Epidemiology:² Endemic foci are found in arid regions, and the seasonal peak of incidence is during the hot, dusty summers.

The probable source of infection is the soil (dust).³ Endosporeulating spherules are not infectious.

High infectivity is proved by laboratory infections and by the rapidity of infection in the San Joaquin Valley.

Morphology: In tissues:⁴ Large, thick-walled spherules containing few or many endospores, which are liberated by rupture of the spherule wall. There are no mycelia. (See Figs. 1 & 2.)

In culture: Mycelium of branched, septate hyphae; white, or brownish, cottony balls.

Pathogenesis: Primary Coccidioidomycosis:⁵ The usual portal of entry is through the respiratory tract, producing pneumonitis; occasionally through the skin. The coccidioidin test is positive in from 3 to 21 days. The primary focus is usually walled off without complication. *Erythema nodosum* (or *erythema multiforme*), a manifestation of allergy, occurs in from 2 to 5 percent of the cases. Other names for the disease are "Valley Fever," "San Joaquin Fever," and "Desert Rheumatism."

Coccidioidal Granuloma results from endogenous dissemination from the primary focus, occurring at the time of the initial infection, or later.

Pathology: Primary infection is indistinguishable, by x-ray studies, from primary tuberculosis. There are no available pathologic specimens. *Erythema nodosum* lesions contain no spherules.

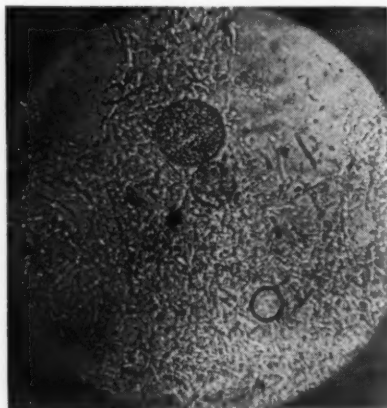


Fig. 1.: High-power photomicrograph of spherules of *Coccidioides immitis* in pus from a "cold abscess." The two larger spherules are packed with endospores.

Coccidioidal Granuloma: Typical granuloma can be distinguished from tubercle only by demonstration of spherules.

Symptoms of a primary infection are: Malaise, chills, fever, anorexia, productive or non-productive cough, headache, backache, night sweats, and pleurisy, with or without effusion. The patient may have erythema nodosum or multiforme.

Granuloma is indistinguishable from tuberculosis, and involves joints, bones, meninges, kidneys, adrenals, lungs, larynx, tubes, testes, skin, or perito-

*Received for publication October 23, 1942.

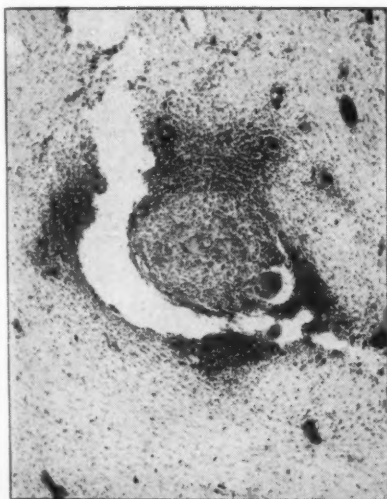


Fig. 2: Low-power photomicrograph of tissue section containing a spherule of *Coccidioides immitis*, surrounded by a typical tubercle-like reaction.

neum. "Cold" abscesses are common.

Diagnosis:

1. Observation of spherules in tissue sections, pus, or sputum.
2. Culture and animal inoculation.
3. Coccidioidin test.⁶
4. Precipitin and complement fixation tests.
5. X-Ray studies:

A. *Primary Infection*: The lungs may show fuzzy densities at the lung roots, with parenchymal lesions.

B. *Granuloma*: Pulmonary lesions are less frequently apical and more rarely associated with cavitation than is tuberculosis. There may be milary "snowstorms," indistinguishable from those of tuberculosis. Osseous lesions more often occur in cancellous bone; are more commonly multiple; and usually have more bone proliferation than is seen in tuberculosis.

Prognosis: Excellent for the primary form; poor for granuloma.

Treatment: *Primary infection*: The treatment is symptomatic—rest in bed, supportive care, salicylates, etc.

Granuloma: Many non-specific drugs have been tried. Vaccine therapy (Jacobson) seems promising. Rest and a high-vitamin, high-caloric diet are always indicated.

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Syphilophobia and Wassermann Reactions

By WALLACE MARSHALL, M.D., Appleton, Wis.

Fears are among the most disturbing maladies with which the general clinician has to deal, and Dr. Marshall here gives helpful information about one of the widely prevalent varieties.

SYPHILIS has become more prominent in the people's minds lately, probably due, in part at least, to the emphasis which the public press has placed upon the subject. It has been associated, in part, with the national war effort, since the relatives and friends of the men in service have been made aware of the lurking danger of this disease in our midst and have learned something

about the Wassermann reaction, but very few lay individuals know the nature of this laboratory adjunct. Many have but a sketchy knowledge of the clinical manifestations of the disease, and this may be wholly inaccurate.

Unfortunately, too much emphasis has been placed upon the results of individual Wassermann tests. The medical profession has, at times, erred in this tendency, for they, too, have based important decisions on the results of this or other similar tests, rather than allowing themselves to be guided by the results of the history, symptoms and clinical findings of each individual

case. In fact we have, at times, allowed the laboratory to make a diagnosis of syphilis for us.

Such a procedure is dangerous and should be corrected at the earliest opportunity, particularly when the clinician finds a report of a "doubtful negative" Wassermann reaction. Obviously, such tests should be repeated whenever necessary, in order to establish the proper status of the case in question; but the condition, in such circumstances, should be viewed in the light of the most important aspects—the history, the symptoms and the physical findings which are ascertained by a thorough physical examination.¹ Laboratory adjuncts should be used only to confirm or rule out such pertinent findings.

Syphilophobia

Syphilophobia (fear of syphilis) is a term which was introduced by Ricard. The relationship between this phobia and actual syphilis has been produced, in many cases, by the interpretation of the Wassermann reaction. Mitchell² aptly says:

"As a clinician, I am not qualified to discuss the technic of the Wassermann reaction. I do not minimize the value of the test, but I think it important to call the attention to some of the unfortunate clinical results of the slightly positive reports given out to the layman and to the medical man who still has unbounded faith in the infallibility of the test. We are all aware of the variations in the results with different antigens, in different stages about the limitations of the test?"
 es of syphilis, in pregnancy, and in early infancy; but have we discharged our duties, to the public and to the general practitioner, by doing our utmost to disseminate the facts about the limitations of the test.

It appears to me that many cases of syphilophobia are produced by the findings from the various serologic tests, more than they are by actual clinical manifestations of the disease. If an unfortunate individual actually has contracted syphilis, there is, of course, some basis for the fear of it. But if he is said to have syphilis merely by the finding of one slightly positive or a doubtful negative reaction to the blood test, there is the probability that he may not actually have the disease. Such reactions must be investigated fully to ascertain the status of such a patient. Nevertheless, the shock of being informed that one

may have such a disease is a most disturbing matter, and might easily endanger the mental well-being of the patient. It may actually precipitate him into a typical neurosis—the fear of syphilis. Such a mental and emotional state was described first by Ricard, and Jordan³ has classified and described it at length.

Cicero⁴ quotes Audry in distinguishing between syphilophobia and syphilomania. He writes:

"Audry defines syphilophobia as obsession by the idea of syphilis, and remarks that the term 'obsession' means 'anguish.' This obsession may exist in individuals not syphilitic, in whom it is 'syphilomania', or in syphilitic individuals, in whom it is true syphilophobia. Of syphilomania, he describes two forms: the common and the grave. As in all obsessions, the idea of syphilis is permanent and irresistible. Furthermore, it is vague; the syphilomaniacs have no clear idea what syphilis is, and yet they ascribe to it all classes of ailments, especially all that present themselves in the genital or cutaneous regions. The cause of these lesions may be pediculosis or herpes progenitalis, or sometimes even something purely imaginary. Syphilomania, according to Chambard, is a case of alienated reasoning."

Cormia⁵ has presented a suitable classification for syphilophobia and the allied anxiety states. This is:

1. Syphilophobia without syphilis: (a) psychoneurosis; (b) temporary phobias, in introspective Latin types and in the medically minded.

2. Pseudo- or questionable syphilis includes (a) and (b) under 1, and may occur in true psychoses.

3. Syphilophobic states in patients with syphilis: (a) neurosyphilis; (b) anxiety neurosis and other psychoneurotic states; (c) neurasthenia syphiliticum; and (d) depressive states associated with constitutional inferiority or with profound psychoses, such as melancholia, manic depressive insanity, schizophrenia, etc.

In a scholarly clinical appraisal of syphilophobia, Gilman⁶ mentions Stokes' criteria in the conduct of all serologic investigations on the patient-suspect:

1. No serologic laboratory, no matter how well and conscientiously conducted, is ever always right in its positive reports.

2. No single positive Wassermann test should ever be accepted as evidence of syphilis under any circumstances.

3. For ordinary practice, as well as for the expert, it is not too much to require both a complement-fixation test and a reputable precipitation procedure.

4. The laboratory report should never be considered apart from the clinical examination of the case. A Wasserman test is part of the case, not the case itself.

A final note is contained in Mitchell's warning that it is unwise to give serologic reports to laymen who are not under the care of a physician.

I might append that such reports should never be given to a patient without finally ascertaining that he understands that such a report does not give the exact status of the case. The physician should contribute his time, with his effort, to impress upon the patient that the serologic finding is but a small part of the total findings at that time. Too much emphasis has been placed upon these tests, so that many patients regard such reports as barometers or indicators of their clinical condition.

As Block has aptly written⁷, "Fear of the unknown always has a more powerful influence upon the individual than fear of the known. Even the bravest, who can face dangers from a known source, fear greatly and are depressed by fears they do not understand. For this reason it is important to study carefully and discover the real basis and mechanism of all phobias, which, when properly explained to a patient may bring a sense of relief."

The Origin of This Fear

Syphilophobia is a peculiar manifestation of the psyche, which is based on the misconception of some stimulus, such as spoken or written words which have to do with the topic of syphilis. Since fear, in its broadest sense, produces a symptom complex which may engender an unhealthy state in the lives of many normal individuals, it is necessary to recognize that this symptom of fear is connected closely with a defense mechanism. This, in turn, is associated prominently with the problem of self-preservation. As Darwin has written, "Fear is, again, the most depressing of all emotions; and it soon induces utter, helpless prostration, as if in consequence of, or in association with, the most violent and prolonged attempts to escape from the danger, though no such attempts have actually been made. Nevertheless, even extreme fear often acts as a powerful stimulant." Fear is, then, a dominant

psychopathogen which can breed a pronounced psychopathologic state if it becomes rampant.

The emotion of fear, in its extreme states, is called terror, and produces action by the vegetative nervous system. The adrenal glands secrete an excess of adrenalin, which produces a rise in the blood pressure and increases metabolism, thus increasing the flow of blood to the organs which are taxed. The end result of such a process is to increase the energy of the muscles so that, in extreme cases, the individual can either run away or fight. If the individual is thrown into combat, the coagulability of the blood is increased, so that the resulting wounds will be less likely to be fatal, and the pupils are dilated, widening the scope of vision. Hence, this process, the result of fear, is a pertinent example of the individual's struggle for self-preservation.

Obviously, such a state, if allowed to persist for a long time, will produce untoward effects. The muscles will become fatigued and the efficiency of such an individual, who is in a chronic state of fear, is markedly reduced.

However, the fears of one individual are not necessarily shared by others, and those that are regarded by one's group as being out of focus with socially accepted reality, are known as phobias or morbid fears. Moreover, certain fears, harbored by one group, may not be the same as those which are found in other groups. It is, then, the group mores which, many times, define or determine so-called normality from abnormality. The nudity of the Melanesians is not wholly accepted by the League for Decency and other groups of Western culturists; and the fear of purgatory, accepted by staunch Roman Catholics, is not shared by other Christians, so customs and beliefs of sociologic or religious origin may play important rôles in imposing certain phobias on the populace.

G. Stanley Hall, some years ago, reported more than 136 medical names for distinct fears or phobias, and many more which did not bear scientific names.

Syphilophobia is produced by certain stimuli, and in most instances these come from the printed page or from conversation. When these are planted upon fertile soil, the autonomic nervous system is involved, and the syndrome is produced.

Management

A sound and useful saying has counseled that "an ounce of prevention is

worth a pound of cure." If the physician bears this in mind, in dealing with neurotic and highly suggestive individuals, he will have accomplished much to prevent the formation of such a phobia, for inadvertent remarks, which at the time may be relatively harmless, may prove to be a stimulus sufficient to produce syphilophobia. Furthermore, misinterpretations or misunderstanding of data, submitted to or by the attending physician, may be of sufficient importance to bring about this state in a suggestive patient. Hence, additional time, taken by the physician, in order to fully explain these findings, may avoid the production of syphilophobia.

I have seen some patients lately, who sought advice because they worried about their constantly positive Wassermann reactions, although they showed no evidence of active syphilis clinically. They had submitted to continued treatment by qualified physicians for a number of years, and had been most loyal in keeping their appointments, yet their blood showed a Wassermann-fast reaction, and this was enough to make them markedly concerned about themselves.

After time was taken to explain the nature of such reactions, most of these individuals were satisfied and their fears were overcome, but two patients continued to worry because of such reactions. Both individuals were single and

feared they could not marry, since our State law requires negative Wassermann blood tests for marriage certificates. I mention these cases to demonstrate why physicians should spend the time and effort, so that the prevalent fears and misconceptions involving this disease can be, at least partially, eliminated.

Syphilophobiacs are suitable material for medical or religious cultists who, in the long run, frequently do further harm. This problem concerns all physicians who treat these unfortunates. It is our problem to see that these persons remain under our care, where adequate medical procedures can be followed, so that a suitable solution to their trouble can be affected.

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Notes From the International Postgraduate Medical Assembly

Reported by GEORGE B. LAKE, M.D., Waukegan, Ill.

THE 1942 International Assembly of the Interstate Postgraduate Medical Assembly of North America was held at the Palmer House, in Chicago, the last week of October. The attendance was not so large as it has often been (about 3,000), but even so was remarkable, under the circumstances, and the physicians who were there were even more obviously intent upon gaining knowledge than usual.

Scientific Exhibit

The 47 scientific exhibits seemed to me to be more practical and instructive than usual.

The Mayo Clinic presented their customary elaborate and educational show, which appeals especially to the strictly specializing surgeons from the larger cities, and Drs. Arthur H. Curtis and

Barry Anson showed the remarkable anatomic drawings that Tom Jones made to illustrate their new book, a review of which appears in this issue.

Of practically universal appeal was "The Story of the Allergic Child" — a graphic and illuminating series of photographs and legends, emphasizing the importance of the patient as a person.

Another booth that had something to say to every active clinician was, "Wheezing that is not Asthma," in which Dr. George L. Waldbott, of Detroit, showed roentgenograms of patients with lung abscess, aortitis, moniliosis, spontaneous pneumothorax, and a number of other lesions producing dyspnea.

Dr. Leo M. Zimmerman and his associates, of Northwestern University Medical School, Chicago, gave an excellent

and illuminating presentation of the *anatomy and surgery of inguinal hernia*, which embodied several important new features.

The Medical Film Guild put on a continuous moving picture show, from 9 A.M. to 6:30 P.M. every day, showing seven different films, with repetitions, so that every man there had a chance to see all of them at convenient times.

The most important point of this exhibit, however, was the fact that any or all of these films are available for showing, *without charge*, before any County Medical Society or other fair-sized group of medical men. Those who are responsible for preparing programs should write to the Guild (mentioning *CLINICAL MEDICINE*), at 167 West 57th St., New York, N. Y., for full details.

Dr. Adolph M. Brown, of Chicago, was demonstrating the clever masking of facial defects with wonderfully lifelike *latex prostheses*, for use in cases where plastic operations must be delayed or are inadvisable for any reason.

Commercial Exhibit

The 126 commercial exhibitors were more or less limited, as to the size and scope of their exhibits, by the restrictions imposed upon many of their activities, but every one had instructive stories to tell about older products — and a few new ones — so that every doctor there had many chances to learn things he did not know before. A few of the new things impressed me as having an especially wide general interest.

Every family doctor must make urine tests daily, and has diabetic patients who must test their own urine daily, to regulate their diet and insulin dosage.

Effervescent Products, Inc., had developed a reliable modification of the well-known and popular Benedict test for sugar, which can be made in *one minute* by any intelligent six-year-old, using a small test tube, a dropper, and *one tablet*, which furnishes all the needed reagents and also generates just enough heat to complete the reaction, at a cost of less than 2 cents a test. This outfit, known as *Clinitest*, will be a blessing to many.

The Ciba Co. has worked out an excellent combination of the vitamin B complex with liver concentrate, vitamin C, and essential minerals, which will meet a real need, and is called *Biotose*.

The Abbott Laboratories offered two valuable new products: *Beclysyl* — a 5-percent solution of dextrose in physiologic saline, for intravenous infusions, each liter of which contains good-sized doses of thiamin, riboflavin, and nico-

tinamide, which compensate for the complete lack of these factors when much pure carbohydrate is given; and *Sterilopes of Sulfanilamide*, which seem to offer the ideal method of applying this indispensable drug locally, in surgery.

Nutrition Research Laboratories, 4210 Peterson Ave., Chicago, distributed (and will send free to any reader who mentions this magazine) a handsome and truly valuable brochure, with several colored illustrations, titled, "Differential Diagnosis of Chronic Arthritis."

John Wyeth exhibited the fourth of Dean Cornwell's magnificent paintings of medical history (perhaps the best, so far), showing Ephraim McDowell about to perform the first ovariectomy.

At the Merck booth, along with an extensive show of British war casualties, there was a practical broadside that is worth recording.

TREATMENT OF WAR WOUNDS

1. If necessary, pack the wound to stop hemorrhage.
2. Cleanse the skin thoroughly, in a wide area, with soap and water.
3. Debride always in contused lacerations with devitalized tissue.
4. With extensive devitalization of tissue, excise the entire wound.
5. In both cases, clean out until the tissue is of normal color and appearance or the wound bleeds freely on section.
6. Use sulfanilamide freely in the wound — up to 10 Gm. per patient.

Here follow abstracts of some of the most practical papers presented.

PRE- AND POST-OPERATIVE CARE OF ABDOMINAL LESIONS

By Vernon C. David, M.D., F.A.C.S.
Chicago, Ill.

Clin. Prof. of Surgery, Rush Med. Coll.

The status of the *plasma protein* is highly important (we now have methods for testing it), and must be normal before operation.

Diabetic patients can now be rapidly prepared for any operation that may be necessary.

The condition of the *kidneys* must be carefully investigated, and no *elective* operation should be performed if they are damaged.

Heart patients can now be operated upon safely, if they are properly prepared (including, perhaps, preliminary digitalization) and if a spinal, local, or other suitable anesthetic is used.

Preoperative catharsis is now out, since it causes a serious loss of fluids. Keep the patient ambulatory as long as possible. A small enema of lukewarm water or salt solution may be given on the morning of the operation.

In all abdominal operations, put an indwelling Levine tube in the stomach before starting the anesthetic. Do not use continuous suction, but aspirate, gently, every 2 or 3 hours. This is especially useful to keep the stomach entirely empty after operations on this organ. The tube may be removed when the stomach begins to function after the operation.

Deficiency states of all sorts should be corrected before operation, if possible. Fat people should be reduced before elective operations.

In a normal person, the insensible perspiration amounts to about 1,500 cc. a day; the bowel needs from 100 to 300 cc. of fluid daily; and the kidneys about 1,000 cc. After an operation the patient loses more fluid in all of these ways, and all such losses (fluid, chlorides, etc.) must be replaced.

Do not keep a patient too warm in bed after an operation; and do not bandage too tightly, as this interferes with abdominal respiration. Begin exercise of the legs early. Do not give too much sedatives, as they stop the cough reflex and otherwise interfere with normal physiologic processes.

BREECH PRESENTATION

By Frank F. Maple, M.D., F.A.C.S.
Chicago, Ill.

Head, Dept. of Obst., Woodlawn Hosp.

Every year, 14,000 babies die as a result of breech presentations, which are three or four times as dangerous as head presentations.

The diagnosis should be made before labor begins, and this can be done by abdominal palpation, with a finger in the rectum or vagina. Roentgrams may give much help. The mother may have pain or discomfort under the costal margin, due to the abnormal presence of the fetal head.

A breech delivery is a surgical procedure. If the legs are extended, splinting the body of the fetus, delivery is almost impossible. The arms should be delivered before pressure is made on the fundus. The limbs and body must

be flexed to make delivery possible.

The common advice, to do external cephalic version, is *not sound*. Let nature work out the problem, and then help. Keep the bag of waters intact as long as possible. A well-flexed breech can deliver spontaneously. Pressure on the aftercoming head, after the arms are out, can be made in the groins or on the fundus: Flexion first; then pressure.

Cesarean section is *not* indicated unless the pelvis is deformed or placenta previa is present. Traction may be safely made on the legs at the proper time, and forceps may be needed to help in delivering the head.

PLASTIC RECONSTRUCTION

By George V. I. Brown, D.D.S., M.D.,
F.A.C.S., Milwaukee, Wis.
Prof. Emeritus of Plastic Surg.
U. of Wis. Med. Sch.

After the war, the family doctor must be prepared to advise patients regarding plastic surgery, and to assist in planning the procedures, because, in these cases, long continued treatment is important. He must get ready, in advance, to perform these functions, and also to carry out after-treatments and adjustments as these become necessary.



DR. BROWN

When gross deformities have been corrected, minor ones, that had scarcely been noticed, become obvious and should be corrected by small surgical operations, by non-surgical treatment, or by both.

Long hospitalization is bad for young men who are otherwise healthy, since it lowers their morale in many ways. When the major surgical work has been done, it is much better to send the patient home and let his family doctor carry on the postoperative and subsidiary managements, in cooperation, perhaps, with the Veterans' Hospital that is responsible for the case.

If much hospitalization seems to be essential, the patient should have frequent periods at home, where he can live with his family and work, under the care of his family doctor.

Much improvement can be achieved, in many of these cases, by long-continued, non-surgical treatments carried out

by the patient himself (under the supervision of the home physician), if an electric current passed through the nerve involved will cause motion.

WAR PSYCHOSES AND PSYCHONEUROSES

By Francis J. Braceland, M.D., F.A.C.P.
Chicago, Ill.

Dean, Loyola Univ. School of Med.

There have been psychoses and neuroses in all wars since the battle of Marathon, but they have been studied only since World War I, during which functional cases were called "shell shock."

Between April, 1917, and December, 1919, there were 110,000 psychiatric casualties in our army. Out of 90 veterans' hospitals at present, 27 handle mental cases, at an average cost to the taxpayers of \$36,000 per patient.

Air raids may cause:

1. Acute panic (only in predisposed persons, and not common), which may be delayed.

2. Immobility ("paralyzed with fright.")

3. Physical, autonomic symptoms of fear (tremors, sweating, etc.).

There is, truly, no such thing as a "war neurosis." The exigencies of war upset only those who were in poor psychic equilibrium before.

The trench warfare of World War I was an incubator of neuroses. It is not present this time, and the number of these cases is less than had been expected.

Care should be exercised by examining boards to weed out the *psychic variants* before they get into the service. However mature they may look, these men are *not adults*. Constitutional psychopathy is not a matter of intelligence nor of physical development. Family doctors could give much helpful advice. The history is far more enlightening than a single intelligence test.

An individual who cannot keep out of trouble in civil life is sure to make trouble in the armed services. Epileptics, also, should be kept out, though many want to get in, and will deceive examiners if they can.

TYPHUS FEVER

By Rolla E. Dyer, M.D.
Bethesda, Md.

Director, Nat'l. Inst. of Health

Typhus fever is caused by *rickettsiae* ("rickettsiosis"), which are midway between bacteria and viruses and are transmitted by rat fleas and human body lice

which, in turn, are carried by rodents. Rat fleas carry the disease from rat to rat or from rat to man, producing the *endemic* or murine form of typhus, which is less severe and is *not contagious from man to man*. Body lice carry the disease from rat to rat and from man to man, producing the more severe *epidemic* form, which is more common in the winter and spring and is associated with crowding, poverty, famine, war, and general misery.

Clinically the flea-borne and louse-borne types are alike, and the symptoms should be fully studied in textbooks. The death rate in the endemic form is low (from 2 to 5 percent) and death is rare in patients of less than 45 years. The severity of the epidemic form also increases with the age of the patient, and the death rate runs from 20 to 60 percent.

In typhus, the rash appears all over the body, except the head, neck, and face, and is heaviest on the trunk. In *Rocky Mountain spotted fever* (also a rickettsiosis), the rash involves the neck, face, scalp, and limbs; the fever lasts longer; the pulse is faster; and the leukocytosis higher. Laboratory tests will differentiate between the rickettsial diseases and others, but not between the rickettsioses.

There is, at present, no specific treatment for typhus, so we must rely on general delousing. Vaccines are strictly on trial.

PENETRATING HEAD WOUNDS

By Ernest Sachs, M.D., F.A.C.S.

St. Louis, Mo.

Prof. Clin. Neurosurg., Washington Univ.
Sch. of Med.



DR. SACHS

A penetrating head wound should be debrided radically and cleaned out (especially macerated brain tissue) with mechanical suction, if available; if not, with a No. 8 or 9 catheter and a hand-bulb Asepto aspirator. Bleeding must be stopped with electrocoagulation, if possible; if not, with special silver clips—not with hemostats or ligatures. When the wound is clean and dry, sulfanilamide powder should be dusted in.

Never close the dura under tension, as this may lead to brain fungus. Close the scalp, in two layers, with silk thread

and without drainage. If much skin has been lost, make a flap and graft the bed from which it was taken.

If a cerebral fungus develops, it must not be cut off, as this might open a ventricle and cause certain death. It should be gradually collapsed by spinal punctures and pressure dressings, which may have to be repeated many times (perhaps twice a day), until epithelium grows over the defect.

If an abscess develops, and becomes sealed off, it can be drained.

INDICATIONS FOR SPLENECTOMY

By Russell L. Haden, M.D., F.A.C.P.
Cleveland, Ohio
Cleveland Clinic

The spleen should be removed in blood diseases; Banti's disease (to stop bleeding from the stomach, since the platelets increase after splenectomy); Hodgkin's disease; idiopathic thrombocytopenic purpura; essential thrombopenia (when there is no splenic enlargement the results are brilliant—12 out of 13 patients lived); congenital hemolytic jaundice; and sickle-cell anemia, if the spleen is enlarged, but not in other types of anemia.

Of patients who are bleeding before operation, only 20 percent will live. Any spleen that is reduced in size after radium irradiation should not be removed.

The contraindications to splenectomy are leukemia, polycythemia vera, and true aplastic anemia.

SYMPTOMS AFTER THYROIDECTOMY

By Lawrence P. Engel, M.D.
F.A.C.S., Kansas City Mo.
Assoc. Prof. of Surg., Univ. of Kans.
Sch. of Med.

Thyroidectomy is never an emergency operation, and unsatisfactory results are due to mistaken diagnosis or inadequate surgery. Psychoneuroses, incipient pulmonary tuberculosis, and brucellosis simulate hyperthyroidism. The basal metabolism test is no more important than any other laboratory procedure, and does not identify Graves' disease in the absence of other symptoms.

The normal thyroid does not interfere with other glands and organs, but the diseased one does.

If an operation fails, in a case of true goiter, it is due to inadequate or untimely

operation or to permanent changes in other structures.

A maximum, subtotal thyroidectomy is best. Untimely operation increases complications, accidents and recurrences. Operate in remissions. If the patient is in crisis, put him at complete rest in bed and see what improvement occurs without iodine. The surgeon should see the patient in crisis before iodine is given. If the condition is serious, give Lugol's solution and then operate.

Immediate symptoms following thyroidectomy may be due to (1) injury to the recurrent laryngeal nerve, which may or may not be serious (be careful: the nerve lies behind the gland); (2) tetany, from removal of the parathyroids, may be mild or severe (be careful: these glands are posterior to the thyroid); or (3) injury to the trachea. A late symptom is an unsightly scar.

These patients must be strictly controlled and carefully watched for a year or more, as it takes several months to establish a new balance, and symptoms can be relieved by suitable treatment that can be carried out by the family doctor.

If the patient is nervous after the operation, give sedatives in minimal doses. At the climacteric, give estrogens or androgens. Thyroid medication helps to establish a balance. Iodine restrains slight hyperthyroid symptoms.

BLADDER AND URETHRAL DISORDERS IN WOMEN

By Roger W. Barnes, M.D., F.A.C.S.
Los Angeles, Calif.

Prof. of Urol., Coll. Med. Evangelists

Urinary frequency, dysuria, and similar symptoms are common complaints of women, but before we can treat them adequately we must find out the exact cause.

In meatitis, aluminum acetate powder, kept in place by a pledget of cotton between the labia, is helpful in all cases. An anesthetic ointment may be used, as required.

Urethral caruncle should be treated with a silver nitrate stick ("lunar caustic") or by the surgical removal of the tissue projecting from the meatus.

Prolapse of the urethral mucosa is different from caruncle. Scarify the projecting tissue, so that it will shrink, or fulgurate it from the ring outward; cauterize granulation tissue, after applying 5-percent cocaine solution for 10 minutes, and use an anesthetic ointment postoperatively.

In infection of Skene's gland, use a



DR. HADEN

skenoscope and destroy the gland by fulguration, or inject a 1-percent or stronger solution of silver nitrate with a blunt-pointed hypodermic needle.

Urethritis is an extension of meatitis. Strip the urethra through the anterior vaginal wall; stain the discharge and examine it microscopically; and make cultures from it.

For **urinalysis**, use a catheterized specimen, if the voided urine shows pus; or an early morning specimen. Identification of the bacteria present is more important (use a Gram stain) for the intelligent use of sulfonamides. If pus is present, but no bacteria, inoculate a guinea pig and look for tubercle bacilli.

If the urinalysis is negative, we must examine for (1) the urethral caliber; (2) residual urine; (3) bladder capacity; and (4) special examinations (pelvic, rectal, etc.).

Granulocitricial urethritis is common. Inject 10 cc. of a 1:1,200 solution of silver nitrate, gradually increasing the strength to 1:500; or a silver protein; or an emulsion of silver nitrate in mineral oil (use a local anesthetic first); or cod-liver oil; or 1:5,000 Metaphen in oil; or some similar preparation.*

Pass one sound at a treatment, beginning with a No. 20 or 22 French size.

Ureteritis may keep up vesical distress. Dilate the ureter and inject a weak solution of silver nitrate. Allergy or endocrine pathoses may give rise to bladder symptoms, and such causes should be identified and treated.

Useful **urinary sedatives** are methylene blue, 2 grains (130 mg.); sandalwood oil, from 5 to 10 minims (0.3 to 0.6 cc.); and oil of copaiba, 5 minims (0.3 cc.), all given, in these doses, three times a day. If the urinary pH is below 5.5, the urine should be alkalinized.

Acute bladder irritation may be due to taking too little fluid; holding the urine too long; alcohol or irritating foods; undue excitement; etc. If it is severe or persists, examine with a cystoscope and give lavage with 1:6,000 potassium permanganate solution.

*Lunosol (Hille) is effective in many cases. —Ed.

In **chronic cystitis**, the cause must be discovered and treated. Sulfacetamide (Sulamyd — Schering) helps in most cases; and sometimes neoarsphenamine, 0.6 Gm., intravenously, once a week, will clear up a difficult case.

STEATORRHEA

By John E. Gonce, Jr., M.D.

F.A.C.P., Madison, Wis.

Prof. of Pediat., Univ. of Wis.
Sch. of Med.

In infants and children, fatty stools are not rare, and the commonest causes are (1) congenital obliteration or later obstruction of the bile ducts; (2) celiac disease; or (3) fibrocystic pancreatitis. In obstruction of the bile ducts, operate.

Celiac disease begins at about 2 or 3 years (not before 10 months); the patient has little or no appetite and no lung symptoms. The stools (4 or 5 a day) are pale (like oatmeal), bulky, frothy, and stinking, and there is abdominal distention and wasting. The fats are well split, but make up about 60 percent of the dry weight of the stools, and carbohydrates are also poorly digested. The cause is not known, but it is *physiologic*, not anatomic.

A cure may require months of careful management, by general care and a diet high in proteins and low in fats and carbohydrates. Use protein or acid skimmed milk; avoid egg yolk and sugars as much as possible, and all carbohydrates and cooked fruits. Raw, ripe bananas† are good; also raw fruit juices — or give 5 mg. a day of vitamin C, and others as indicated.

Pancreatic disease begins before the age of 10 months; shows anatomic lesions and lung symptoms; the patient is always hungry; and the malady is always fatal. The diet is similar to that in celiac disease, but with more fat. Pancreatic extracts will ameliorate the condition, but will not cure it.

307 Washington St.

†In the absence of bananas, certain other raw fruits may be used. —Ed.

BIRTH CONTROL AS A PUBLIC POLICY

There is a high differential birth-rate in favor of the least intelligent classes of the population, sufficient to make a pessimist of any one conversant with the facts. Its serious consequences can be prevented only by teaching birth control where it is most needed as a public policy, and this we do not seem inclined to do. —C. W. SELLERS, M.D., in "The Decline of Wits."

A LIVING FOR THE DOCTOR

THE BUSINESS OF MEDICINE AND THE ART OF LIVING

Planned Reading

WHEN one realizes the immense amount of reading that is done in this country, one tends to be appalled by the meager results that appear in the lives of the general run of people one meets.

We must remember, however, that there are three general purposes in reading: For *knowledge* (professional and trade books and magazines, and other similar matters); for *culture* (philosophy, poetry, the "classics," extra-curricular reading of history, biography, general science, and the like); and solely for *recreation*. For most people, the last-named is the only type of reading they do, and that accounts for the paucity of their general knowledge.

He who would gain knowledge (the raw material of wisdom) and culture (the intuitive perception of the best, in all or many lines) must do a good deal of reading with a definite purpose and a formulated plan. He must find out (by the advice of informed persons or by trial and error) what books, out of the enormous field of real literature, will best serve his purpose, and then make a detailed plan for approaching them, setting aside specific periods of time for pursuing such studies, and then following that plan religiously.

But he must do more than that. He must read with his *mind*, as well as with his eyes, *making notes* of the new facts he is learning or perceptions he is acquiring and *putting them to work*, at once, in his daily life, if he expects to retain them.

It will be vastly helpful if he makes his notes dealing with various subjects on *separate cards* (the 4 by 6 size is handiest for most people), and then *indexes* them and files them alphabetically, for quick reference.

Anyone who will carry out a program of planned reading such as this consist-

ently, for only six months, will be so astonished and delighted at the permanent and useful additions to his knowledge and culture that he will never abandon the practice.

This does not mean that the serious student should never read for simple recreation, but that when he does so, he should do it, as he would undertake any other play, with a clear understanding of what he is doing, and not confuse it with his serious reading or permit it to usurp hours he has set aside for what really counts in his scheme of life.

G.B.L.

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Symptoms

THE despair of young physicians at being unable to understand the vagaries of symptoms, as contrasted with the relative constancy of pathologic changes, would be lessened if they realized that *symptoms are merely the patient's interpretation of what he feels*. They are not astonished when two persons of different temperaments react differently to the same physical or mental stimulus, as applied in the laboratory. The pain of venipuncture is intolerable to the introspective, highstrung patient, yet a lumbar puncture may not distress the stolid patient, who has a high threshold for pain.

Socalled "symptom books," which list each symptom and follow it with a discussion of its possible causes, would be of inestimable value if all patients would respond alike to the same pathologic condition. As it is, any one of a half-dozen or more symptoms may be the initial and predominating one.

A fact that is even less generally considered is that the order of appearance of physical signs also varies, at times widely, with the type of the patient's physical constitution.

Possibly this is all for the best. If signs

and symptoms could be predicted exactly, it would only be necessary for each family to equip itself with a "family doctor book," and follow its instructions, as

they would those contained in the brochures that come with washing machines and vacuum cleaners—with distressing results.

R. L. G.

Notes and Abstracts

Issues in the A.M.A. Case

The Supreme Court has limited to three the number of questions it will consider in reviewing the conviction under the anti-trust laws of the American Medical Association and the affiliated District of Columbia Medical Society, but these three cover plenty of ground.

The Supreme Court memorandum indicated that the following would be the points considered:

Issues Listed

1. Whether the medical profession is subject to the anti-trust laws.
2. Whether the Sherman Act is limited solely to price-fixing and business competition.
3. Whether a medical association can be classed with labor unions in respect to immunity the latter enjoy under the Norris-LaGuardia Act.

In the answers to these queries, lawyers are interested as members of the public, of course, but more particularly as members of a profession having many features in common with that of the doctors. — *Pittsburg Legal Journal*.

The Problem of the 30-Cent Telegram

"Send a telegram to Doctor Medico and tell him that he's authorized to draw on me for the \$75 I owe 'im," the patient suggested.

"Thirty cents," the Western Union operator told him, and the patient handed it over.

"Draw a draft according to that wire, attach the telegram, take them down to the Sand Bank, and get the cash," Doctor Medico told his secretary-nurse.

"How do we know that he owes the doctor or that he'll accept the draft when it gets there?" the cashier demurred.

"Look at the telegram attached," the secretary suggested.

"Oh yes, that makes it all right," the cashier agreed, handed over the cash, the draft went forward, the patient did

not pay, and the bank "came back" on Doctor Medico.

"Sue him, and I'll stand the costs," the doctor suggested.

"We can't. He didn't accept it," the bank pointed out.

"That telegram I sent you's an acceptance," Doctor Medico argued.

"I doubt it."

"Go ahead and I'll take the responsibility."

"Well, it's your look-out," the cashier retorted.

The bank sued the patient—and won, as the Oklahoma Supreme Court, in the case of *Bank vs. Muskogee*, 139 Pacific Reporter, 1136, has decided in favor of the bank under the same circumstances.

"It is clear from the testimony that this telegram was exhibited to the bank and attached to the draft before it was honored and paid," said the Court. "This evidence also showed that the drawee paid for the transmission of the telegram. This, we think, shows a sufficient acceptance."

—M.L.H.

When Doctor Chooses Doctor

Refuse to discuss a doctor's ailment with him unless you are being asked to treat him. But if you are, don't let him share the responsibility; treat him as you would any other patient. And when you yourself are ailing, choose your doctor as decisively as you choose your solicitor, and put yourself as unreservedly in his hands.—*Lancet* (through *Lilly's Physician's Bulletin*).

War Bonds for Larger Buyers

For those who have bought the legal limit of Series E bonds (cost price, \$3750), and want to buy more, bonds of Series F and G are now offered. The former have a face value of \$1000, payable in 12 years, and cost \$740; for the latter, one pays \$1000, receives \$12.50 interest every six months for 12 years, and is then to have his original payment refunded. Ask your local banker for details.



THE SEMINAR

Readers are invited to submit problems to the Seminar and take part in the discussions, which should reach this office by the 10th of the month following the appearance of the problem. Send problems and discussions to THE SEMINAR, CLINICAL MEDICINE, Waukegan, Ill.

Problem No. 10—1942 (Medical)

Presented by Ralph L. Gorrell, M.D.,
Clarion, Ia.

RECAPITULATION: A woman of 28 years, who had always been well until two years ago, when she had a clavicle fracture, complained of nervousness, weakness, tachycardia, and palpitation. She had lost 20 pounds in weight and her menses, formerly free, had become scant.

Examination: Pulse, 108; temperature, 99.4 F.; respirations, 21; blood pressure, 160/98; skin, warm and moist; hemoglobin, 65 percent; red blood cells, 4,200,000; tuberculin test, 2-plus positive; brucellergin test, positive; otherwise she was practically normal. No roentgram or basal metabolism test was made.

Requirements: State your diagnosis and describe, in detail, how you would have handled this patient.

Discussion by W. B. Palmer, M.D.,
Furman, Ala.

In this case, both tuberculosis and brucellosis must be kept in mind. Too much confidence must not be placed in the brucellergin test, for it merely indicates that the patient is allergic to the brucella organisms from some past or present attack of brucellosis, of which there are several varieties, such as bovine, caprine, and porcine. Recent investigation has shown that a skin test does not vitiate a subsequent agglutination test, which always aids in reaching a diagnosis. Where there are proper facilities the opsonocytaphagic test is helpful.

Brucellosis and tuberculosis can co-exist. They can even attack the lungs at the same time in the same individual. In such a case the pleural fluid, sputum, and roentgram may be negative for tuberculosis, though the patient has that disease.

Weakness, sweats, anemia, a fluctuating fever, and other symptoms are characteristic of both diseases. Such a rapid loss of weight by this patient suggests a dormant tuberculous process, activated by the invasion of brucella organisms. The entrance of either fresh tubercle bacilli or brucella organisms may activate dormant tubercle bacilli. Many persons are attacked by tubercle bacilli and the condition passes unnoticed. Nature barricades the organisms. It is a secondary invasion or an insult to the body otherwise that may cause the blocked organisms of tuberculosis to become virulent and often fatal. It is an allergic response.

The symptoms and treatment are similar in both diseases, the latter including rest in bed and a balanced and full, but not excessive, diet with a high vitamin content. With tuberculosis, there should be rest for the lungs, by restraining the cough, voluntarily or by sedatives. Collapse of the lung must always be kept in mind.

With both diseases, "an ounce of prevention is worth a pound of cure." To prevent brucellosis, aid the government in testing and exterminating cattle that are infected, and pasteurize or boil all milk for human consumption. The disease is more common than it is supposed to be, for the low mortality of from 1 to 6 percent and the mildness of the symptoms in so many cases cause skepticism, even among physicians.

Vaccine and the less-commonly-used protein and fever therapy, used in brucellosis, are contraindicated in tuberculosis.

Discussion by Dr. Benjamin Gross,
Camden, N. J.

In this case, we are dealing not only with a problem in diagnosis and therapeutics, but with a definite economic or social situation as well. Dr. Gorrell writes: "She felt that she could not afford a chest x-ray study or a basal

metabolism test." Here is a circumstance with which every physician is confronted daily. It is not within our scope to analyze this situation, but it should be mentioned in the hope that men experienced in sociology might find a solution.

In the medical problem, nervousness, palpitation, tachycardia, and weakness are the predominating symptoms. Let us try to visualize the possibilities.

1. *Undulant fever*: The only factor in the discussion that makes one consider brucellosis is the marked reaction to the brucellergen test. We know that human beings may become infected through the ingestion of milk from infected goats and cows or by the flesh of these animals, and through the skin. Therefore, we would like further information as to the possibility that this patient may have partaken of these foods; whether other members of her household ate the same foods, and whether they developed the same symptoms; and whether there was any history of wounds (even pin pricks) in the presence of these animals.

The brucellergen skin test is very sensitive, and pathologists are not prone to accept it except to rule out undulant fever if it is negative. We insist on blood and urine cultures, as conclusive evidence. The opsonocytophagic test definitely determines whether infection or immunity is present.

2. *Tuberculosis*: The fever, loss of weight, sallow appearance, and the two-plus positive tuberculin test must be considered seriously. The history does not reveal any recurrent colds, hemoptysis, coughing, expectoration, or dyspnea. On physical examination the lungs were negative, and her sputum was negative for tubercle bacilli. Undoubtedly a roentgenogram of the chest would be of value, but I feel that a negative physical and laboratory examination outweighs the tuberculin test, which shows merely that this patient had tuberculosis in the past.

A leukocyte count would be of interest, with leukopenia and relative lymphocytosis suggesting tuberculosis. The blood sedimentation rate would be rapid in an active case of this disease.

3. *Malaria* can easily be eliminated by the history and a blood test for plasmodia.

4. *Graves' Disease*: The history mentions a runaway accident (a perfect example of psychic trauma), since which she has been a little nervous. Her symptoms—nervousness, tachycardia, palpitation, weakness, a warm and slightly

moist skin, and loss of weight or failure to gain weight—suggest Graves' disease. No mention of exophthalmos is made, and no thyroid was palpable, but these signs are not essential to this diagnosis.

Fever, with or without sensations of heat, is common in exophthalmic goiter, although the rise in temperature is never great (between 0.5° and 1.5° F. above normal, usually toward the end of the day). Care should be exercised to rule out a focus of infection as the cause of the fever. The decreased menstrual flow is a common symptom of an overactive thyroid. A basal metabolic study was needed, but as the patient's economic status did not permit it, there are two other methods of approaching this problem:

A. *Reed's Formula*: The pulse rate (108), plus the pulse pressure (62), minus 111, equals plus 59 in this case. This is considered, by some, as a fairly accurate way of appraising the metabolic rate, but must be accepted with caution.

B. *The quinine test*: The patient should be given 12 capsules, each containing 10 grains (0.65 Gm.) of quinine hydrobromide, and instructed to take one capsule three times a day (t.i.d.) for four days. If no evidence of dizziness, headache, gastric distress, bladder discomfort, impaired hearing, or tinnitus appears, the reaction may be considered positive for hyperthyroidism.

If these tests are positive, we are justified in treating the case as one of hyperthyroidism, and prescribing physical and mental rest, an ample, nutritious diet, elimination of tobacco, iodine (used carefully), sedatives, and such other methods as may be called for in the individual patient.

I have found that small doses of quinine (from 1 to 5 grains three times a day) help these patients. If it is not obtainable, physostigmine, $\frac{1}{500}$ to $\frac{1}{4}$ grain (0.32 to 0.9 mg.), t.i.d., may be tried.

A useful prescription, in the absence of quinine, is:

R
 Prostigmine bromide gr. $\frac{1}{4}$ —0.0100
 Sajodin gr. $\frac{1}{2}$ —0.0320
 Phenobarbital gr. $\frac{1}{4}$ —0.0160
 Physostigmine salic. gr. $\frac{1}{500}$ —0.0005

Make 21 such capsules.

Sig: One (1) capsule three times a day, before meals.

If anemia is an important factor, the patient should take 2 tablets of Feosol, t.i.d. Some estrogenic preparation, such as theelin may be indicated.

If the case is one of Graves' disease, various physical therapy procedures

may be helpful; and psychotherapy, with reassurance and emotional reeducation, is always in order.

Discussion by O. W. Johnson, M.D., and J. W. Fletes, Michigan City, Ind.

From facts given in this problem we suggest a tentative diagnosis of *chronic undulant fever and hyperthyroidism*. The undulant fever, in our opinion, is of longer duration than the thyroid disturbance.

The few "rheumatic nodules in the neck muscles" and the history of weakness prior to the examination are suggestive of brucella infections, which usually run a chronic, low-grade course. The change in character of the menses from heavy to scant, and also the "few hot flashes," suggest ovarian deficiency, probably more of a toxic syndrome from brucellosis than a natural transition, because of her age (28 years).

It is well known that the glandular system is delicately balanced, and that a change in one gland will create or lessen demands on another or on a group, hence, hyperthyroidism. A thyroid gland need not be "palpable" to be toxic. The basal metabolic rate in this case would probably have been at least plus-30.

Treatment: Surgery of the thyroid would be a last resort. Hyperthyroid patients do well on large doses of estrogenic hormone, especially this type of case. Undulant fever would be treated with sulfanilamide and type-specific brucella vaccine. Later, an effort should be made to stimulate the ovaries with the cautious use of the gonadotropic pituitary hormone.

Discussion by L. E. Williams, M.D., Kansas City, Mo.

The principal diseases which must be considered in connection with the symptoms complained of by this patient, the history given, and the physical and laboratory findings are: typhoid, malaria, Hodgkin's disease, undulant fever, Addison's disease, syphilis, leukemia, tuberculosis, thyrotoxicosis, chronic rheumatic fever, and subacute bacterial endocarditis.

Malaria and typhoid are considered mainly because of the chronic febrile condition. The pulse rate of 108, for a temperature of 99.4° F., is too rapid for typhoid. A Widal's serum test would be of value in eliminating this condition. There is no history of chills, and the preponderance of evidence is inconsistent with this condition. A blood-cell count, including a differential, and a

search for the malarial organism are indicated.

Hodgkin's disease, in addition to palpitation, tachycardia, pyrexia, loss of weight, anemia, and weakness, is characterized by a generalized enlargement of the lymph glands. The absence of glandular enlargement is against Hodgkin's disease, but does not eliminate its possibility.

Syphilis must be eliminated, as it is a great imitator of diseases, and because of its propensity to attack the cardiovascular system, causing tachycardia, palpitation, hypertension, and many other conditions.

Addison's disease also causes tachycardia, palpitation, progressive loss of weight, anemia, and a positive tuberculin reaction. Furthermore, it produces a characteristic pigmentation of the skin, and hypotension is more likely to be present than hypertension.

Undulant fever or tuberculosis could account for most of the symptoms and findings in this case, except the hypertension. The oligomenorrhea is probably due to the anemia and is nature's way of protecting the patient. If the patient has undulant fever or tuberculosis, we must find some other pathosis to account for the hypertension. The positive brucellergin reaction, while suggestive, does not necessarily mean that the present condition is due to that disease. The same may be said of tuberculosis regarding the positive tuberculin reaction.

I am of the opinion that, if the patient was suffering from tuberculosis, the attack would have been more fulminating in character, the fuse having been lighted at the time of her accident. This is not necessarily so, and tuberculosis still must be considered. The diagnosis of chronic leukemia, in the final analysis, depends upon the blood findings.

Thyrotoxicosis must be strongly considered, even in the absence of thyroid enlargement. Since a basal metabolism test could not be obtained, resort to Goetsch's method of testing the patient's sensitiveness to epinephrine, or the therapeutic test with thyroid extract, is both indicated and justifiable. However, with a blood pressure of 160 systolic and a diastolic of 98, I am inclined to believe that the trouble is not in the thyroid gland, because in thyrotoxicosis the diastolic pressure is more likely to be normal or subnormal, even though the systolic is high.

It would be helpful to know whether there were any cardiac arrhythmias, murmurs, or enlargement. Tachycardia, palpitation, weakness, loss of weight,

easy fatigability, "funny spells" (dizziness, fainting), a low-grade fever, the presence of fibrositic nodules in the muscles of the neck, a blood pressure of 160/98, accompanied with a history of frequent attacks of tonsillitis, are suggestive of a cardiovascular disturbance of rheumatic origin. If the heart findings were negative, I would treat the patient for chronic rheumatic fever. On the other hand, if there were positive evidences of valvular or endocardial involvement, my diagnosis would be subacute bacterial endocarditis and I would treat the patient about as follows:

Complete rest; a high-caloric diet with vitamins A, B, and D (which is good treatment for tuberculosis); phenobarbital for rest and hypertension; sulfanilimide (also indicated in undulant fever); and, as the patient is highly nervous, reassurance is badly needed (psychotherapy).

Since the brucellergen reaction was strongly positive, it might appear that antibrucellosis serum was indicated, but I know of no specific treatment for undulant fever that can be absolutely relied upon to produce a cure. In fact the brucellergen test alone, when strongly positive, may be as effective in producing a cure as the specific serum.

Solution by Dr. Gorrell

The basal metabolic rate was determined to be plus three. A chest film was finally taken in 1942. Dr. Rigler, chief of the x-ray department at the University of Minnesota, reported on the film: "There are multiple calcifications in the right lung and a few in the left lung, suggesting an old, childhood tuberculosis. There are some calcified peribronchial lymph nodes on the right. No evidence of any recent or active lesions in either lung could be made out. The heart appears within normal limits. There is evidence of an old fracture of the right clavicle, which has united in poor position."

Final diagnosis: Undulant fever (as shown by the brucellergen skin test); ovarian failure.

Menstruation became more free after injections of Theelin, and has since been

normal while she is taking 1 grain of thyroid extract daily. No special treatment was given for the undulant fever, aside from rest and hematinics for the secondary anemia, as there is no successful specific treatment for mild, subacute brucellosis. She has gradually improved and now feels well.

Problem No. 1—1943 (Medical)

Adapted from a Clinico-Pathologic Conference

A married Negro man, 62 years old, with no children, complained of shortness of breath, a "stuffy" feeling in his chest, and swelling of the legs and feet, all of which began 18 months previously and had grown worse. He said that 4 months earlier a doctor had given him digitalis.

His family history was negative. He had a "sore" on his penis, 25 years ago, but no skin rash. He had felt "weak" for two years, but had had no fever and lost no weight. The urine was scant and passed frequently (8 or 10 times a night), and the appetite was poor, but he had no pain or digestive symptoms.

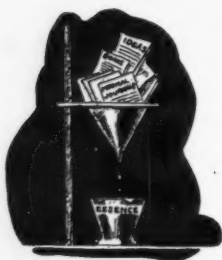
Physical examination showed a well developed man, not apparently acutely ill. The only positive findings were pyorrhea and carious teeth; bulging and pulsation of the jugular veins, more marked on the right; a few moist râles posteriorly; enlargement of the heart, with a "to-and-fro" murmur over the aortic area and a blowing systolic murmur at the apex; moderate arteriosclerosis; temperature 95° to 98° F.; pulse, 93 to 110; blood pressure, 122/50; liver three fingerbreadths below the costal margin and slightly tender; urine showed albumin, + to +++, with many pus cells and casts and some red blood cells; blood, hemoglobin, 60 percent; red cells, 3,440,000; leukocytes, 10,400 with 63 percent polys; and Wassermann test 4+.

Five days later the patient was found comatose in the morning, and died in the afternoon.

Requirements: State your diagnosis, giving reasons, and what further studies you would have made.

MAKING DECISIONS

While an open mind is priceless, it is priceless only when its owner has the courage to make a final decision which closes the mind for action after the process of viewing all sides of the question has been completed. Failure to make a decision after due consideration of all the facts will quickly brand a man as unfit for a position of responsibility.—KALENDS OF THE WAVERLY PRESS.



CLINICAL NOTES and ABSTRACTS

Microfilm copies of any of the published papers here abstracted, up to 25 pages, may be obtained for 25 cents from Microfilm Service, Army Medical Library, Washington, D.C.

Pruritus Ani*

THE more common causes of pruritus ani are: (1) Nervous exhaustion, or nervousness; (2) local fungous infections (due to moisture and warmth of perianal region); (3) local abnormalities, including hemorrhoids, fissures, fistulas, and neoplasms; (4) intestinal parasites, especially pinworms; and (5) contact dermatitis, due to the use of medicines locally, or to sulfite toilet paper. Diabetes is an important cause.

Diagnosis: (1) The nervous type of patient is easily recognized because of his constant tension, restlessness, easy fatigability, and over-activity; (2) fungous infections may be recognized by scraping the perianal area and finding the mycotic organisms by microscopic examination (the scrapings are placed on a glass slide, cleared with 2 drops of 10-percent potassium hydroxide solution, covered with a cover-slip, flamed several times, and examined); (3) anal examination will discover abnormality or disease; (4) stool examination and scrapings from the anal region will show intestinal parasites or their ova; and (5) contact dermatitis may be suspected by the history.

Appearance: The skin may appear normal, or scratch marks may be present. Small areas of lichenified dermatitis may be present, because of persistent scratching. Mild secondary infection and maceration are frequently present and may appear as white, soggy areas.

Treatment: (1) Potassium permanganate sitz baths (1:6,000 strength) for 30 minutes, twice daily; (2) Castellani's carbol-fuchsin-resorcin paint should be applied locally, twice daily, following the sitz baths; (3) calamine lotion containing 50 percent olive oil, $\frac{1}{4}$ percent menthol, and $\frac{1}{2}$ percent phenol should

be sopped on thrice daily and whenever needed to control the itching (calamine lotion without the olive oil may irritate the anal mucosa because of its drying effect); (4) phenobarbital, in 32 mg. ($\frac{1}{2}$ grain) doses, three times daily; (5) no soap or water locally; (6) toilet tissue should be moistened before using, after which olive oil, mineral oil or cold cream should be applied locally (local cleanliness is extremely important); (7) scratching and rubbing must be avoided; and (8) bowel movements must be kept soft and regular with mineral oil, taken by mouth.

In the neurogenic type, it is well to make an attempt at slowing down the individual. Midday naps, sun baths, frequent vacations, and reeducation along the lines of a more restful way of living, are frequently helpful.

RAY NOOJIN, M.D.

Durham, N. C.

Diet in Edema

When edema occurs, the diet must contain the smallest amount of salt possible. Salt-free butter should be used; meat should be boiled and the broth not used by the patient; no crackers, pretzels, cheese, sausages, salted meats or fish, prepared salad dressings, canned soups, beer, or patent medicines for the relief of gastric distress, are permitted. The patient may eat freely of flour, cream, macaroni, sugar, potatoes, squash, parsnips, lettuce, kidney beans, tomatoes, and most other vegetables and cereals. Moderate amounts of eggs, meat, milk, beets, brussels sprouts, corn, mushrooms, peas, and spinach may be eaten. Salt should not be used in the baking of bread or rolls.

The patient's weight should be watched closely. Give ammonium chloride, in 1

*South. Med. and Surg., July, 1942.

Gm. (15 gr.) doses, eight times a day for 5 days and repeat after five days period if the weight is not reduced to the previous level.

Oliguria or anuria is treated by the intravenous injection of from 500 to 1,000 cc. of a 20-percent solution of dextrose, two or three times daily. — W. DRECKMANN, M.D., in J.A.M.A., Oct. 24, 1942.

New Things of 1942

The use of *sulfanilamide* and *blood plasma*, after the Pearl Harbor raid, resulted in the healing of practically all *abdominal wounds* without infection; and only 4 percent of compound fractures and flesh wounds became infected.

Promin gives some promise of being a successful drug treatment for *tuberculosis*.

Vitamin C was reported as being effective in *heat cramps* and *heat prostration*, and its use for preventing *surgical shock* was suggested.

Thiamin and *riboflavin* seem to be important factors in resistance to bacterial infections.

Albumin from human blood was used successfully in treating *shock*, and efforts are being made to develop a safe albumin from beef blood, to be used for the same purpose.

Demerol, a new synthetic analgesic, was reported to come nearest to being a safe substitute for morphine.

Prostigmine gave good results in the treatment of headache and dizziness following *concussion of the brain*.

It now seems probable that certain toxic reactions from the *sulfonamides* are caused by interference with the absorption of some unidentified factors of the *vitamin B complex*.

If *sulfathiazole* is used within the skull, it may cause convulsions and death.

Penicillin (the germicide from mold) is now being prepared, as its barium salt, a 1:12,000,000 dilution of which will stop the growth of most strains of *Staphylococcus aureus*.

Male sex hormone was found to promote the functional activity of the kidneys.

Airsickness, and similar conditions, originally caused by disturbance of the organ of equilibrium in the inner ear, may also be due to conditioning to other motions, sights, and smells, and can be prevented and cured by psychotherapy.

Individuals who have recently taken sulfa drugs may make *wrong decisions*

because of the *mental confusion* that sometimes follows their use.

Sub-shock doses of *electric current* through the brain were found to shorten the duration of *delirium tremens*.—*Science News Letter*, Dec. 19, 1942.

Punctures of the Feet

The patient is laid flat on a table with the injured foot elevated on a small pillow or block. Rubbing alcohol is swabbed over the wound, which is usually sealed and looks insignificant. Using a double-edged razor blade, flexed between

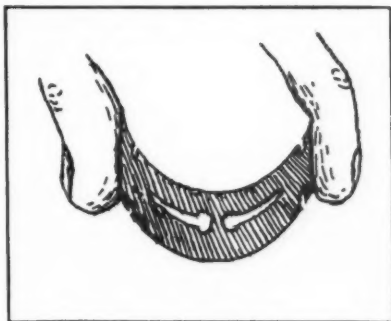


Fig. 1: Diagram of handling razor blade.

the thumb and fingers to make a curved cutting edge (See Fig. 1), a circular patch of plantar callus about one inch in diameter is removed, leaving thin pink skin around the nail hole. At this depth there is a jagged opening containing bloody, watery fluid and often dirt, sand, or rust, depending upon the condition and environment of the nail. The remaining irregular edges of this wound can be trimmed with the razor blade or with cuticle scissors. It has thus been converted from a sealed pocket, covered by a plate of unyielding callus, to an open wound surrounded by an area of soft thin skin. Debris may be picked out of the wound with small forceps, or washed out with soap and water or peroxide, using pledgets of cotton. Alcohol is again applied and the wound protected by a small dry dressing, which the patient is advised to remove before going to work next day. Antitetanic serum is administered to all patients with nail puncture wounds.

The patient is told to stay in bed until time to go to work the next day; keep his leg elevated above the level of the body; and *abstain* from soaking his foot in hot water, which is a popular, but bad, practice.

No patient, seen within 24 hours after the injury and thus treated, has lost more than a part of one day from work or developed infection or tetanus. — MAURICE A. WAIKER, M.D., in *J. Kans. M. S.*, Nov., 1942.

Newer Knowledge of the Menopause

The menopausal process may be divided into three periods: (1) the period of corpus luteum failure; (2) the period of decreased estrogenic secretion; and (3) the period of atrophy of the accessory organs.

milk. Butter, cream, olive oil, gravy, pie, cake, bread, pork, or fried foods, should *not* be eaten. Small doses of thyroid extract ($\frac{1}{4}$ to 2 grains) may be used daily, if the basal metabolic rate is determined periodically and kept below plus 15 percent.

The hemoglobin should be raised to 11 Gm. (80 percent), by giving blood or iron. If there is no anemia and the serum proteins are low, they may be increased by the transfusion of plasma, serum, or lyophile serum.

The mercurial diuretics, such as Salygran, have not produced diuresis in pregnant patients. Ammonium chloride, po-

	1st Stage	2nd Stage	3rd Stage
Clinical Picture	Large, soft uterus; profuse menstruation; few menstrual symptoms.	Hot flushes; increased menstrual distress; smaller uterus and breasts; scantier flow.	Atrophy of breasts, ovaries, and uterus; few symptoms; pruritis vulvae, senile vaginitis, kraurosis, leukoplakia.
Physiology	Ovary does not respond to pituitary stimulation; corpora lutea abnormal or not formed.	Decreased amounts of estrogen in blood and urine; ovarian follicles do not respond; increased gonadotropic hormone in urine.	Little or no estrogenic hormone; no increase of pituitary gonadotropic hormone.
Curettage; Laboratory studies	Cystic glandular structures in a hyperplastic endometrium.	Urine examination. (See above)	Atrophic endometrium.
Treatment	Meno-metrorrhagia is treated by curettage (which also rules out cancer); Progesterone or stilbestrol during period of bleeding.	10,000 units of estrogen, injected every other day for 7-10 days; then weekly. Orally, 0.5 mg. of stilbestrol daily, or from 12th to 24th day of cycle, if still menstruating.	Suppositories of estrogenic hormone for vaginitis — 6 weeks therapy; vulvectomy for leukoplakia; biopsy for suspicious nodules, ulcer, or fissure about vulva.

—DELLA DRIPS, M.D., in *Journal-Lancet*, Dec., 1942.

Excessive Weight Gain During Pregnancy

The average weight gain during pregnancy should not be more than 250 Gm. per week for the last 28 weeks. Excessive gains in weight are usually due to edema (although none may be demonstrable), and are treated by decreasing the caloric intake. This is more easily accomplished by cutting down the fats instead of the carbohydrates.

The diet, each day, should consist of vegetables, fruits, lean meats (broiled, roasted, or boiled), eggs, and 1,000 cc. (one quart) of skimmed milk or butter-

tassium chloride, or potassium nitrate may be given, in 15 gr. (1 Gm.) capsules or tablets, from 8 to 12 times daily for five days, and then repeated after five days without medication. The patient should not use salt in cooking or on foods.—W. J. DIECKMANN, M.D., in "Toxemias of Pregnancy" (C. V. Mosby Co.)

[In a number of personal cases, the use of Salygran was entirely ineffective in increasing the output of urine. If salt can be rigidly limited, the edema of pregnant women can usually be handled rather readily by the use of 90 gr. (6 Gm.) daily of ammonium chloride. —R.L.G.]

Health and Fuel Rationing

The medical profession has a definite responsibility in connection with the application of fuel rationing, especially during the winter months.

The old are very sensitive to cold. The skin is less well supplied with blood vessels, and though this may be useful in diminishing the heat loss, it may also account for the increased sensitivity of the skin to cold.

Shortage of fuel may breed a corresponding economy of fresh air, because it is cold, and the avoidance of proper ventilation will thus favor infection, acute or chronic. Lobar or bronchopneumonia, common in the old, may be so latent that sudden death of an ambulant subject may be ascribed to old age, and a necropsy showing pneumonia may be a surprise.

Fuel restriction may interfere with the cooking and serving of food; a poor appetite in old age may thus be deprived of any stimulus due to such attractions. — SIR HUMPHREY ROLLESTON, M.D., F.R.C.P., in *Med. Press & Circ.*, July, 1942.

Chilling

A fact not generally known about chilling is that it is not the cold that does the harm when one is chilled; it is the failure of the body to make a prompt, normal reaction. A man whose skin and circulatory organs are trained to react to cold will not suffer.

Those who are sensitive to cold may overcome this tendency by exposing the upper half of the body, for one minute, to cool air, while rubbing the skin or exercising vigorously. After a few days, the time can be increased to five and even ten minutes, and the remainder of the body exposed (*except the feet*). The exposure should not be carried out long enough to produce shivering or severe chilly sensations. — *Good Health*, Dec., 1942.

The Diagnosis of Arthritis

Arthritis is not a local disease of the joints; rather it is a *disease of the entire body*, with manifestations in the joints. Many patients suffering from the arthritic syndrome (fibrositis, "rheumatism") may show little or no true arthritis. Focal infection is occasionally a cause of arthritis. In both rheumatoid (inflammatory) arthritis of younger persons and osteoarthritis of older persons, the manifestations are symmetrical, although osteo-

arthritis may be aggravated in one joint by trauma.

Low-grade edema is found in many patients with arthritis. Both hands are cold and sweaty. Further evidence of the generalized nature of arthritis is shown by the exacerbation of symptoms at the time of menstruation, the incidence of arthritis in women at the menopause, and the retrogression of arthritis during pregnancy. These patients stand cold poorly. Recent studies show that many are achlorhydric (a fact long known clinically, by the response to dilute hydrochloric acid given with meals), and many have poor gallbladder function and atonic colons (colonic irrigations have value). *Arthritis is basically an imbalance of the central nervous system and endocrine glands.* — RALPH PEMBERTON, M.D., in *Arch. Phys. Ther.*, Oct., 1942.

[Stimulated by the work of deTakats on peripheral circulation and the fact that vasoconstriction is present in most arthritic patients, injections of procaine solution have been made into the sympathetic nervous system — stellate ganglion in the neck and paravertebral injection in the low back. The dramatic change from a slightly cyanotic, cold, sweaty hand to a painless, pink, warm, dry one is accompanied by relief of pain. — R.L.G.]

Sugar and Dental Caries

The combination of sugar and saliva results in acid formation, which removes a small amount of calcium from the teeth. This may be prevented by having the patient brush the teeth immediately after eating and use large amounts of water, which is swished forcibly between and around the teeth before being swallowed. If possible, a stick of antiseptic paraffin should be chewed also. This procedure should be carried out after each meal and especially after eating candy or other sugary food. If it is impossible to brush the teeth, the washing out with water should be performed. Few patients will carry out this method perfectly, but they will be rewarded by having little or no dental caries. — L. S. FOSDICK, M.D., in *J. Am. Dent. A.*, Dec., 1942.

[This method has a background of clinical and laboratory experience, and agrees with findings on natives who have been exposed to the sugar and starchy foods of the "civilized" diet.—Ed.]

The Diagnosis of Fatty Stools

The distinguishing characteristic of all forms of sprue is the passage of bulky, pale, fatty and gaseous stools. These stools appear in:

1. Celiac disease	A congenital disorder of infancy; carbohydrate foods cannot be digested.
2. Idiopathic steatorrhea	Apparently a continuation of celiac disease; often accompanied by multiple skeletal changes.
3. Nontropical sprue	Sprue syndrome arising in persons who have never been in the tropics.
4. Tropical sprue	

Symptoms: Dyspeptic distention of the abdomen, frequent diarrhea, soreness of the mouth and tongue, progressive emaciation, defective calcium metabolism, definite anemia, signs of avitaminosis, and a tendency to remission and relapse.

Signs: Distention of the abdomen, with flabby, stretched muscles; pallor and signs of undernutrition. The *roentgenographic* appearance of the small bowel is that of smooth segmentation of the loops, while the colon is enlarged and redundant. Anemia may be hyper- or hypochromic in type. Soreness of the tongue, mouth, and pharynx is common; the tongue may be atrophic and the mouth lesions may resemble those of pellagra. The skin may be dirty and waxy or yellowish. Carpopedal spasms and muscular cramps may appear as signs of calcium deficiency. Petechial hemorrhages may appear.

The stools have increased amounts of total fats. Blood sugar levels are low and do not increase after taking sugar. Achlorhydria is common.

Treatment includes a high-protein, low-carbohydrate diet (fruits, vegetables, honey, meats, liver). Transfusions may be needed at first. Liver, iron, calcium and vitamin D, vitamin B complex, and vitamins C and K are used to control R. B. HAWES, M.D., in *Pract.*, Sept., 1942. their respective deficiency symptoms. —

Factors Affecting Breast Milk

Worry, fear, and other strong emotions cause a decrease in the amount of milk secreted. Injections of Adrenalin or epinephrine cause a lessening of milk, due to vasoconstriction (asthmatic mothers should take as little Adrenalin as possible). Incomplete emptying of the gland causes a back pressure on the

secreting alveoli and hastens involution. See that the breast is emptied each time, by a pump, if needed.

Nursing should be begun as soon as possible after delivery, and continued over a long period, before failure is admitted, as the act of nursing stimulates the pituitary gland to secrete lactogenic hormone.—W. E. PETERSON, M.D., in *Journal-Lancet*, Dec., 1942.

Biotin

The structural formula of the remarkable substance, biotin, has now been determined and is announced as being a five-membered urea ring, a ring containing sulfur in thio-ether linkage, and a fatty acid side chain.

The first isolators of biotin obtained only 1 milligram from 500 pounds of dried egg yolks, so the substance is very expensive; but it produces noticeable effects in the astonishing dilution of 1 part in 400 billion.

The discovery of the chemical formula is the first step toward its synthesis which would provide material for the extensive research which must be carried out with it before its powers and properties can be fully estimated.—J.A.M.A., Jan. 2, 1943.

Psychologic Reactions to Prolonged Inadequate Heating

The main psychologic effects as a result of prolonged inadequate heating will be lowering of morale, inefficiency in work as a result of apathy, and the production of a resentful, disgruntled attitude toward those in authority. It is not often recognized that many people will stand up better, psychologically, to undernourishment than they will to poor heating over any length of time.

Efficiency will suffer if workers are asked to carry on in factories, offices, etc., which are cold. Nor can one heat places of work adequately and have private homes cold, for the worker will, therefore, not have a place for relaxation or recreation. Instead of working or resting at proper intervals, the people will be spending their time trying to keep warm.

It is well known that cold tends to produce a depressed frame of mind, with lethargy and apathy. Adequate heating may thus become essential to maintain efficiency and cheerfulness.—LOUIS MINSKI, M. D., M.R.C.P., in *Med. Press & Circ.*, July 15, 1942.

Staphylectomy

Observation of a series of more than 3,000 cases indicates that many reflex throat disturbances improve markedly after complete removal of the uvula. Patients subjected to this procedure almost invariably report the following sequelae:

1. Freer nasal ventilation, almost without exception, within the first 72 hours.
2. Diminished nasal secretion and "postnasal drip" and cessation of early morning paroxysms of "hawking."
3. Unquestionable reduction in susceptibility to "colds."
4. Prompt symptomatic relief from painful sinus involvement (maxillary and frontal), truly dramatic in a majority of instances.

The topical use of 4-percent cocaine or any of the synthetic substitutes, adequately applied, renders the procedure practically painless. Manipulation of the tongue-depressor is delegated to the patient, thus enabling the operator to handle freely the other two instruments employed, viz., Noyes' alligator-jaw forceps of medium size, and serrated tonsil-scissors, the latter being used points down. Because of the markedly impoverished vascularity of the uvula, post-operative bleeding is negligible and usually subsided spontaneously within 5 minutes. In some cases there is practically no bleeding at all.

There appears to be no relationship between the actual size of the uvulae and their aggravative influence in the catarrhal syndromes with which they were associated. Complete removal is essential.—ARTHUR E. EWENS, M.D., in *E.E.N. & T. M.*, Aug., 1942.

Cautions for Local Anesthesia

If a hematoma is produced by the needle with which a local anesthetic is injected, do not inject epinephrin procaine solution near it, as the solution may rapidly find its way into a vein, resulting in an intravenous injection and subsequent nervous excitation. For the same reason, do not inject close to a hemangioma.

If a patient becomes much excited during or after local anesthesia, give enough barbiturate solution (Pentothal-Sodium), intravenously, to relax him.

Only a small amount of epinephrin or other vasoconstrictor should be given with the procaine solution. If arterial disease is present, it is preferable to

use very little or none at all, as necrosis may follow. Epinephrin should never be used in injections around fingers or toes, as their small arteries are end-arteries and gangrene may follow their narrowing. If an epinephrin injection results in a high systolic blood pressure, $\frac{1}{100}$ gr. (0.65 mg.) of nitroglycerin may be placed on the tongue, or the patient may inhale amyl nitrite.

If hypertension is persistent, give a 2 cc. ampule of sodium nitrite (3 gr.) slowly, intravenously. The action is prolonged. By giving it slowly, the correct amount to lower the blood pressure can be gaged.

Do not sterilize metal-glass syringes by boiling, because the cement will be loosened. After drying all needles, blow air through them and put in a drop of thin oil. — E. B. TUOHY, M. D., in "Lewis Practice of Surgery." (W. F. Prior Company).

Diet for the Old

1. Elderly people should start the day with a good breakfast. It should include some substantial protein, and whatever else depends on body weight and activity. *Protein adequacy must be maintained at all ages.*

2. As effort lessens and sedentary life supervenes, weight rise or fall should dictate the proportion of carbohydrate taken, and as much of this as possible should be from whole grain. While bran is objectionable, cracked wheat products are not. Enriching flour may be a good expedient, but the objection to dark breads should be lived down. Potato is the next best starch.

3. For the obese, vegetables and fruits should act as the "fillers" and provide appetite and zest for eating by meticulous preparation and serving.

4. The elderly should eat fat sparingly, even as the middle aged should use it cautiously. The high cholesterol sources (egg yolk, cream, and animal fats) should probably be curtailed wherever the body build, family history, and other indications portend atherosclerosis. It is the one decisive indication for dietary restriction after full stature has been attained. The danger of high blood cholesterol is not universal.

5. Tea, coffee and alcohol are useful stimulants. The abuse of alcohol places it, for some people, in the category of both refined carbohydrate and animal-source fat. As a vasodilator it inspires as well as flushes the aged. One cannot say as much for tobacco. It soothes and

cuts off circulation. The quiet postprandial puff is rapidly becoming a continuous process. Tobacco is safer after 60 than before, because age has by that time made the blood vessels less elastic and labile.

6. Food and water (hot drink), taken at regular intervals, revive the old. Food becomes the best sleep producer, even though early wakefulness follows. Fruit juices add the needed vitamin content.

7. Hunger lessens as age advances. Foods useless calorically (condiments, broth, relishes) have a place. The teeth, gastric acidity, probably absorptive powers, and vitamin storage—all begin to fail with age. We are able to compensate for these losses with vitamins, iron, calcium, hydrochloric acid, and a balanced diet. The mouth becomes the nutritional barometer of health. —EDWARD J. TUOHY, M.D., in *J.A.M.A.*, Jan. 2, 1943.

Uses of the Duodenal Tube

The duodenal tube may be used for feeding in cases of gastric or duodenal ulcers, with or without obstruction; for duodenal instillation of fluids in cases of dehydration, hemorrhage, and after

operations; for suction of gases from the obstructed bowel; for duodenal lavage in cases of persistent vomiting, simple icterus, cholecystitis, cholelithiasis, and cholangitis; and for duodenal instillation of medicines (constant drip therapy of ulcers; giving nauseating medicines). —C. KRIEGER, M.D., in *Rev. Gastro-Enterol.*, Nov.-Dec., 1942.

Duodenal Ulcer

Uncomplicated duodenal ulcer is a medical disease. The patient must be educated to the fact that he suffers from a chronic illness, that he must consider himself ulcerous or potentially ulcerous for the rest of his life. He must be taught permanently to avoid those tension states which are the common cause of recurrence. He must learn to live permanently on a restricted diet, which need not necessarily be too uninteresting. He must be taught to avoid upper respiratory infections and grippe and to go to bed if they are acquired. He must permanently give up smoking, and must discontinue the use of concentrated alcoholic beverages. An occasional beer or light wine with meals is not harmful. —MANFRED KRAEMER, M. D., in *Jour. Med. Soc. N. J.*, May, 1942.

MEDICO-MILITARY NOTES

Treatment of War Wounds

The actual treatment of any war wound should always be based on 5 fundamental biologic principles. They are: (1) Prompt surgical treatment; (2) cleansing of the wound; (3) excision of the wound; (4) provision of drainage; and (5) immobilization in a plaster-of-Paris cast. Proper organization must enable surgical treatment to be given with a minimum of delay, to avoid infection.

Spinal anesthesia should never be used in shocked patients. Gas-and-oxygen should be used only by experienced anesthetists, and if they are not available ether should be used. A shocked patient requires much less anesthetic than a fit subject.

No antiseptic is equal to soap and water in dealing with a contaminated wound. For the skin, a solution of iodine or similar antiseptic should be used. At

the end of the operation the wound may be dusted with sulfanilamide.

Excision of the wound is the keystone of the whole technic. The wound must first be enlarged, since damage to deeper tissues is often much greater than that to the skin in wounds caused by explosives. After excision of the dead skin and fascia, the operation proceeds layer by layer, in successive stages of incision and excision, until the bottom of the wound is reached. The periosteum, however, must never be incised.

Drainage is provided by gently inserting dry, fine-mesh gauze into the intramuscular spaces. A flat layer is laid over the wound surface. Where a deep, narrow cavity is present, a rubber drain is inserted into the most dependent part.

The only method that will prevent initial absorption of toxic products from the wound, protect granulation tissue and growing epithelium from injury, and provide an effective barrier to secondary

infection is the use of a plaster-of-Paris cast. This should be applied directly to the skin, except over the bony prominences. It should be well molded to the limb, particularly over the wound, where it will be in contact with the gauze and absorb discharges and maintain gentle pressure.—J. TRUETTA, M.D., in *Brit. M. J.*, May 15, 1942.

New Plans for Medical Education

The Army and Navy, cooperating with the American Council on Education and other agencies, have worked out specialized training programs to take care of the medical and premedical students, under 22 years old, whose professional services will be urgently needed later.

Briefly and in general, the plans provide for the enlistment or induction of these young men into the Army or Navy, where, if they are up to the standards set for officers' candidate schools, they will be assigned to continue their course of instruction, in selected colleges, under military discipline, while wearing the uniform and receiving the pay and maintenance—and also the military training—appropriate to their grades.

The curriculums will be intensive and accelerated.

Full details are not now readily available, but can be obtained from local Draft Board officials or from the Surgeons General of the Army and Navy.

Moreover, internships will be definitely limited to 12 months, and will be of the rotating type. The interns will not be commissioned as medical officers of the Army of the United States until 60 days before they are to go on active duty, but meantime will be protected from the Draft by special agreement, by Medical Administrative Corps commissions, or Reserve Line commissions, which they will receive when they are graduated from college.—*J.A.M.A.*, Jan. 2, 1943.

Appeals Procedure

If an individual physician, dentist, or veterinarian, or the institution employing him, does not agree with the decision of the state chairman as to his availability for service elsewhere, the individual or his employing agency may request a reconsideration of the decision by the state committee. If the original opinion is upheld by this committee, appeal may be made to the corps area chairman and his committee.

If the decision of the state committee is still sustained by the corps area com-

mittee, the individual concerned or his employer has the further privilege of submitting his case to the central office of the Procurement and Assignment Service.—*J.A.M.A.*, Dec. 5, 1942.

Tropical Medicine Specialists

Special, intensive courses in tropical medicine are now being given, at the Army Medical School, Washington, D. C., to medical officers and to certain civilian members of the faculties of various medical schools, who are granted permission to take the course and whose expenses in doing so will be paid by the Markle Foundation.

A class of more than 100 was graduated on December 12, and a new class, of the same size, was immediately started. Full details of these courses can be obtained from the School.

Suicide and War

One of the rare possible benefits of war seems to be a consistent decrease in the suicide rate in all the countries involved, probably due to the cooperative national effort transcending selfish personal troubles.

Between 1939 and 1941, the suicide rate fell 15 percent in England, 30 percent in Germany, and in the United States the rate in 1941 was considerably below that for 1940, though the figures are not yet complete.—*Statist. Bull. Metrop. Life Ins. Co.*, Sept., 1942.

Water Disinfection

When, in an emergency, water which has not been properly treated on a large scale must be used for drinking, there are several methods for disinfecting it:

1. It may be *actively* boiled for two minutes, if fuel is available.

2. A stock solution of *chloride of lime* may be made with one teaspoonful of the chloride (24 percent available chlorine) to one quart of water, and kept in a well-stoppered bottle. One teaspoonful of this solution is well mixed with two gallons of water and allowed to stand for 30 minutes.

3. Ten (10) drops of *Zonite* added to one gallon of water (or 7 teaspoonfuls to 50 gallons) and allowed to stand 30 minutes will disinfect it.

4. Add 4 drops of *tincture of iodine* to one gallon of water and let it stand 30 minutes before using.—JOHN H. O'NEILL, in *New Orleans M. & S. J.*, Aug., 1942.



DIAGNOSTIC POINTERS

Chronic Hoarseness

• Patients with chronic hoarseness should be suspected of having laryngeal and pulmonary tuberculosis, and a tuberculin test and chest x-ray study should be made.—R. HOFFMANN, M.D., in *Dis. Chest*, Nov., 1942.

Pleurisy

• Pleurisy, especially if effusion follows, is caused, in 80 percent of cases, by tuberculosis.—R. HOFFMANN, M.D., in *Dis. Chest*, Nov. 1942.

Lingering "Colds"

• The acute upper respiratory infection ("cold," "grippe," or "influenza") that does not subside within the customary period of time, may mark the onset of acute tuberculosis.—R. HOFFMANN, M.D., in *Dis. Chest*, Nov., 1942.

Sequelae of Brucellosis

• The most striking feature of brucellosis is the prolonged period of disability which follows the acute course. *Weakness or easy tiring is the most common complaint.* Recurring mild fever, stiffness or painful muscles or joints, headaches and backaches, general aching, anorexia, palpitation, and sweating are often complained of.—I. F. HUDDLESON, M.D., in "Brucellosis in Man and Animals" (The Commonwealth Fund, New York City, Publishers).

Symptomless Menopause

• A pituitary type of menopause may occur at any age. The pituitary gland fails to produce an excessive amount of gonadotropic hormone or fails before the ovaries do. *There are no symptoms with such a menopause, regardless of the age at which it occurs.* —D. G. DRIPS, M.D., in *Journal-Lancet*, Dec., 1942.

Hematuria with Colic

• Hematuria, followed by renal colic, suggests a new growth of the kidney.—A. FISHER, M.D., in *Med. World* (Lond.), Nov. 1942.

Pallor and Anemia

• All anemic people are pale, but by no means all pale people are anemic. *Anemia is the most commonly diagnosed but the least frequently recognized of all diseases.*

My experience has been that most patients referred for blood studies have no anemia; anemic patients are sent in with some other tentative diagnosis based on the leading symptom:

Symptom	Disease suspected
Fatigue.	Tuberculosis.
Shortness of Breath.	Heart disease.
Swelling ankles.	Nephritis or heart disease.
Trace of Albumin.	Nephritis.

Clinical points: Examine the color of the conjunctivae and mucous membranes rather than the color of the skin. A white skin may be nourished by a blood rich in hemoglobin and red blood cells, yet may be paler than that of a patient with a definite anemia.—M. E. SHAW, M.D., in *Brit. Med. J.*, Sept. 21, 1941.

Fatigue

• Illness, be it of mind or body, is due largely to two factors, undernourishment and fatigue. Weir Mitchell was the first to show that full feeding and rest would work wonders with the patient who has many psychoneurotic complaints.—T. B. THROCKMORTON, M.D., in *Ill. M. J.*, Dec., 1942.

Urinary Obstruction

• Many infants and young children are treated for digestive disturbances, malnutrition, or as difficult feeding problems, when the real cause is failure of kidney elimination from lesions in the kidney or an obstruction in the lower urinary tract (bar across the bladder neck, urethral valve, small urethral meatus, phimosis).—F. J. PARMENTOS, M.D., in *N.Y.S.J.M.*, Apr. 15, 1942.

Orthostatic Albuminuria

• In a young person whose urine contains albumin, and in whom the absence of casts and other evidences of renal disease suggest the diagnosis of adolescent or orthostatic albuminuria, the presence of a large amount of globulin in the urine tends to confirm the diagnosis.—A. FISHER, M.D., in *Med. World* (Lond.), Nov., 1942.



THUMBNAIL THERAPEUTICS

Acute Tonsillitis

• The direct application of 50-percent guaiacol to acutely inflamed tonsils is momentarily painful. Following this procedure, however, the inflammation subsides rapidly and in 24 hours the tonsils almost regain their normal appearance. — E.E.N. & T.M., Dec., 1942.

Plug Running Ears

• Persons with otitis media should wear cotton plugs in their ears while outdoors or around animals. The larvae of flies are frequently found in the ear, especially in warm climates, in cases of purulent otitis media, and may burrow into the tissues of the nose or ear and cause much damage. *Treatment:* Chloroform, vapor or liquid, kills larvae. — F. M. TURNBULL, M. D., in *South. Med. & Surg.*, Nov., 1942.

Combined Immunizations

• There are now available commercially combined or mixed agents for immunizing against several diseases at once (whooping cough and diphtheria; diphtheria and tetanus). Such a procedure does not reduce the amount of immunity produced to each disease, but actually increases it. — N.Y.S.J.M., Dec. 15, 1942.

The Treatment of Draining Abdominal Wounds

• Granulating, cracked, or blistered skin around a draining abdominal wound may be treated by applying a 10-percent solution of zinc chloride, which permeates abraded surfaces but does not penetrate unbroken skin.

The skin may be protected from irritation from a discharging fistula by using a thick layer of zinc stearate powder. The discharges are caught on pads placed at the patient's side, and the entire region enclosed in a cage containing electric light bulbs. — W. WAYNE BABCOCK, M.D., in *Miss. Doctor*, Sept., 1942.

Orchitis with Mumps

• Severe orchitis, necessitating morphine for its relief, should be treated by opening the scrotum and permitting the hydrocele fluid to escape. A crucial incision, $\frac{3}{4}$ inch in length, is then made in the tunica albuginea. The scrotal wound is closed with silk sutures. Relief of pain is immediate and fever subsides rapidly. Subsequent atrophy of the testicle is prevented. Operation should be done without delay if the testicle is very tender, unyielding, and of stony hardness. — S. VOSE, M. D., in *New Eng. J. Med.*, Aug. 20, 1942.

Vitamin B in Dry Sockets

• The severe pain of a "dry socket" after tooth extraction can, in 69 percent of cases, be permanently relieved within 30 minutes by intramuscular injections of thiamin hydrochloride (vitamin B₁). In practically all cases this distressing condition can be prevented by giving the patient thiamin, by mouth, for 5 days before an extraction, with a hypodermic injection one hour before the operation. — DR. J. P. OSTERLOH, in *J.A.D.A.*, Aug. 1, 1942.

Prevention of Measles

• Every child who is to be admitted to a children's ward (or exposed in a home where other children are suffering from measles or rubella) should first receive an injection of 30 cc. of blood taken from several donors (pooled serum or plasma). Measles will be aborted. — L. H. BARENBERG, M. D., in *Med. World (Lond.)*, Aug. 28, 1942.

Non-Specific Urethritis

• If no gonococci can be found on repeated examinations of a urethral discharge, the condition is probably a non-specific urethritis, caused by a small meatus or one or more strictures of the urethra. *Treatment:* (1) incision of the meatus under local anesthesia; (2) gradually increasing dilations of the urethra; and (3) one of the sulfonamides, in 30 grain (2.0 Gm.) doses daily. — R. THOMPSON, M.D., in *South. Med. & Surg.*, Sept., 1942.

NEW BOOKS

Any book reviewed in these columns will be procured for our readers if the order, addressed to **CLINICAL MEDICINE**, Waukegan, Ill., is accompanied by a check for the published price of the book.

The true University of these days is a collection of books.—CARLYLE

GYNECOLOGY

Curtis

A TEXTBOOK OF GYNECOLOGY. By ARTHUR HALE CURTIS, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of the Gynecological Service, Passavant Memorial Hospital, Chicago. Fourth Edition, Reset. With 401 illustrations, chiefly by Tom Jones. Philadelphia and London: W. B. Saunders Company, 1942. Price, \$8.00.

Curtis' textbook combines usability and theory. It is intensely practical, yet basic sciences, especially anatomy, are not neglected.

The beautiful sketches by Tom Jones and the many clinical photographs are well worth studying for their own teaching value. The author, with Barry Anson, has been carrying out studies in gynecologic anatomy which are here reproduced in illustrations. Anyone interested in gynecologic surgery can save himself many hours of dissection by studying these drawings. Surgical technic for each condition is given in connection with the discussion on that topic.

The section on diagnosis and treatment of gonorrhea has been entirely revised in the light of the action of the sulfa drugs and the new material on cultivation of the gonococcus.

With this fourth edition, Curtis' textbook is entering the classic stage.

RATIONING DOCTORS

Anderson & Baylous

WHEN DOCTORS ARE RATIONED. By DWIGHT ANDERSON, Director Public Relations, Med. Soc. of the State of New York, and MARGARET BAYLOUS, Therapist, Charleston (W.Va.) Gen. Hosp. New York: Coward-McCann, Inc., 1942. Price, \$2.00.

Doctors are now being rationed, to the fighting forces, public health services, industry, civilian communities, etc., by the Procurement and Assignment Service.

This book tells why and how this is being done and how physicians and their patients can fit into the uncomfortable picture. The doctors can find here the answers to a number of questions in their minds; and laymen can get helpful suggestions as to choosing a new medical attendant (as long as choice is permitted to them) when their family doctors are called into the Services.

Here is an illuminating picture of wartime Socialized Medicine, which will give both doctors and laymen a chance to see how they like it. The book should be widely and carefully read.

GERIATRICS

Thewlis

THE CARE OF THE AGED (GERIATRICS). By MALFORD W. THEWLIS, M.D., Attending Specialist, General Medicine, U. S. Public Health Hospitals, New York City, etc. Fourth Edition; 50 illustrations. St. Louis: The C. V. Mosby Co., 1942. Price, \$7.00.

The problem of the care of our older citizens looms larger every year, and geriatrics appears to be the coming specialty in medicine, which will be most largely practiced by family doctors.

Dr. Thewlis, who is one of the pioneers in this field, here gives an excellent presentation of the subject, including chapters on hygiene and diet in senescence; prevention of premature senility; work for the aged; hobbies and economic problems; physiologic and pathologic changes; allergy, alcoholism, and focal infection; sex life; and many others.

Infectious, cardiovascular, genitourinary, digestive, respiratory, skin, and other types of diseases, as they affect elderly people, are discussed in detail, with helpful suggestions for their management. There is also a chapter on surgery in the aged.

The book has nearly 600 pages; working bibliographies follow each chapter; the index is adequate and the bookwork good.

Here is a volume that every general clinician can profitably add to his library, and those who study it and apply its teachings will be better doctors and more capable human beings.

MALNUTRITION

Quigley

THE NATIONAL MALNUTRITION. By D. T. QUIGLEY, M.D., F.A.C.S., Milwaukee, Wis.: Lee Foundation for Nutritional Research, 1943. Price, \$1.50.

The thesis of this interesting volume of 113 pages (15 of which are occupied by an adequate index) is that the chief cause of illness and general incapacity in this country is malnutrition, resulting from the fact that, hitherto, no one has known what constitutes a normal, scientific diet and, therefore, that our mass standards of normality are based upon groups of persons who have eaten inadequately all their lives.

The nine chapters deal with dietary needs in general, and specifically with the necessity for an adequate intake of all the vitamins and essential minerals, since deficiencies in these elements are practically never single. The chapters on the prevention and treatment of cancer, and the nutritional treatment of anemia, are especially thought-stimulating.

The basic suggestion of the author (scientifically defended) is that the chief factors in overcoming the national malnutrition would be the abolishment of highly-refined white flours and sugars and the substitution of whole-grain flours, ground freshly every day by the bakers, and the wider use of natural sugars, such as honey, and fresh fruits.

The author's style is sound and dignified, but so simple that it can be understood by any housewife, which makes it a book to be studied by all family doctors (who are the men upon whom dietary improvement must depend), and loaned or recommended to their patients who keep house.



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